INSURANCE COORDINATOR/ASSOCIATE COORDINATOR VERIFICATION FORM

Department for Employee Insurance
Enrollment Information Branch
501 High Street, 2nd Floor
Ph# (502) 564-1205
Fax# (502) 564-1085
Attn: Teresa Shipley

(Only the primary Insurance Coordinator can be set up in our system to receive automatic email.)

Company Number_____ **Agency Name**_____

Insurance Coordinator Name_____

SSN_____ **Birthday**_____

Email Address_____

Phone Number_____ **Fax Number**_____

Begin Date _____**End Date**_____

Do you need Web QE Access with Ceridian? Yes/No
(To trigger COBRA notification)

Is your fax machine HIPAA compliant? Yes/No
(Is this machine used by the IC/ AIC only?)

Associate Insurance Coordinators

Name_____

SSN_____**Birthday** _____

Email Address _____

Phone Number_____**Fax Number** _____

Begin Date_____**End Date** _____

Do you need Web QE Access with Ceridian? Yes/No
(To trigger COBRA notification)

Is your fax machine HIPAA compliant? Yes/No
(Is this machine used by the IC/ AIC only?)

Name _____

SSN_____ **Birthday**_____

Email Address _____

Phone Number_____ **Fax Number**_____

Begin Date _____ **End Date** _____

Do you need Web QE Access with Ceridian? Yes/No
(To trigger COBRA notification)

Is your fax machine HIPAA compliant? Yes/No
(Is this machine used by the IC/ AIC only?)